Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

2009 Medicaid Transformation Program Review
Medicaid Fee-for-Service Prior Authorization Processes

Description

The primary purpose of prior authorization (PA) is to facilitate cost containment by ensuring fee for service (FFS) medical services provided to Medicaid/HealthWave beneficiaries are medically necessary and cost effective. This is accomplished by identifying, researching, and reviewing designated procedures or services, and implementing measures to promote performance and reimbursement of services considered to meet the specified criteria set forth by KHPA.

KHPA outsources this function to its fiscal agent HP. Registered nurses perform these functions, except for transportation services. When the information supplied does not meet State medical criteria and the fiscal agent's staff has questions, the request is forwarded to the KHPA program manager (SPM) or the KHPA Medical Workgroup (MWG).

PA is a basic tool for managing health care through reimbursement. The objective of the PA process is to encourage appropriate use of care, discouraging unnecessary or inappropriate care and encouraging appropriate care. The end result is generally to lower costs and improve care for beneficiaries. The Kansas Medicaid/Healthwave programs must only reimburse for basic, medically necessary, appropriate, and cost effective services. The PA process is the mechanism for providers to request approval of a service before it is performed. Not all services require PA. Program Managers review their programs to determine whether or not requiring a PA is beneficial.

PA requests may be received by telephone, fax, internet or mail and entered into the MMIS. As necessary, the request can be systematically routed to other staff for review. After the review is completed, the providers and beneficiaries are notified in writing of the approval or denial of the request. Telephone calls are logged into an ACCESS database. Entries are made by the PA staff involved with the call. These notes are maintained within the database and are retrievable by the PA staff.

The status of each of the requests for prior authorization is maintained in the MMIS prior authorization master file. During claims processing, the master file is searched prior to payment being made for a service identified as needing prior authorization. The prior authorization of specified units or dollar amounts, are automatically adjusted as services are billed. The process allows for a single provider to request authorization of needed services on behalf of any providers who are also associated with rendering that specific service. Attending surgeons, anesthesiologists, and other providers participating in delivering the service are allowed to bill using one PA number. During the claim editing process, the PA master file is verified to ensure the primary procedure has been authorized for the beneficiary.
The PA Unit also supports the entry of Home and Community Based Services (HCBS) plans of care and the tracking of those services. The plans of care are entered by designated case

managers or data entry staff and electronically routed to the appropriate SRS or KDOA staff for approval. The PA Supervisor and Call Center Representative maintain the HCBS helpdesk. In addition to the provider community, access to the PA system is given to private entities, such as Kansas Health Solutions, Cenpatico and the Mental Health Consortium, who are responsible for entry and approval of PA requests for services provided. Access by other State partners may be arranged as needs arise.

Claims are processed by the PA unit when the MMIS system identifies that a claim is related to a specific PA requirement. PA staff also review certain claims related medical necessity criteria. Claims processed by the PA Unit fall into one of the following categories:

- A PA is required for the claim to process
- A medical review is necessary (such as when a provider bills for certain Services such as an MRI)
- QMB Pricing is required
- Medical necessity must be determined by a nurse's review of the case (including reviews of all SOBRA cases)
- The claim denies as it is suspected to be a duplicate claim
- The billing is for a non-covered service
- Manual pricing is required

Kansas Administrative Regulation (KAR) 129-5-1 provides that any medical service may be placed by the Kansas Health Policy Authority (KHPA) on the published list of services requiring prior authorization or precertification for any of the following reasons:

- To ensure that provision of the service is medically necessary;
- To ensure that services that could be subject to overuse are monitored for appropriateness in each case; and
- To ensure that services are delivered in a cost-effective manner.

KAR 129-5-1 goes on to state that failure to obtain prior authorization, if required, shall negate reimbursement for the service and any other service resulting from the unauthorized or noncertified treatment. Likewise, if a prior authorization is approved, it will approve any other reimbursement(s) to providers associated with the specific service that was approved. The only exception to obtaining prior authorization shall be:

1. Emergencies where it is not reasonable to obtain PA. The PA may be obtained within two working days after the service is provided
2. Situations where services requiring PA are provided and retroactive eligibility is later established.

PA Activities and Expenditures

The Medicaid Fiscal Agent, HP, employs eighteen (18) staff in the PA Unit, with twelve (12) of those individuals being Registered Nurses (RNs). One of the RNs is the unit supervisor. The staffing has remained the same despite the fact that the number of PAs processed is about 10% lower than it was in 2005. The time involved with processing the PA requests has not changed significantly (shown in Figure 3a).

Table 1 identifies the costs associated with the PA Department.

Table 1 – PA Expenditures and Cost Savings

FY	PA REQUESTS	PA COSTS AVOIDED	Denied Claim Costs Avoided	CONTRACT STAFF	COST OF CONTRACTOR	STATE STAFF	COST OF STATE STAFF
2007	66,435	$6,352,904	$22,781,971	18	$2,094,331	0.25	$16,539
2008	66,632	$6,566,498	$13,770,432	18	$2,187,153	0.25	$16,539
2009	67,751	$5,622,970	$29,483,095	18	$2,268,315	0.25	$16,539

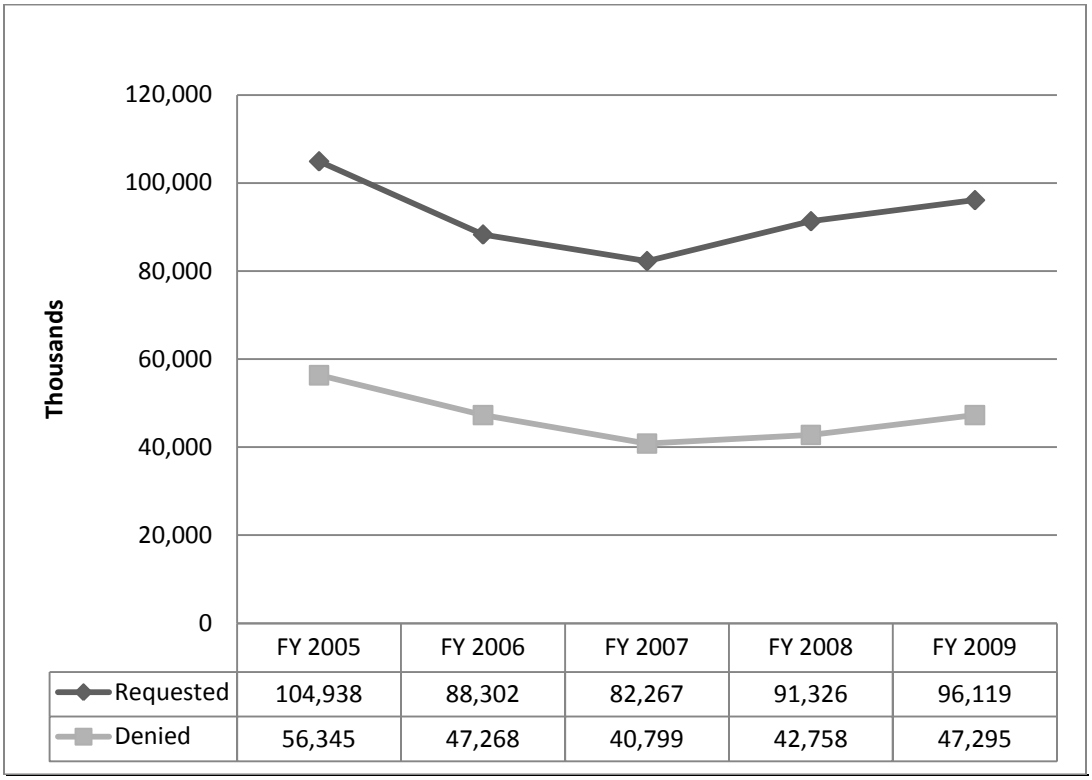
Table 2 depicts time allocations for PA staff time

Table 2 – FY 09 Staff Allocations

Category	Total	Avg Time	Time Based Staff Avg	Current Staffing
PA Receipts	67,751	20.25	13.5	13.5
Claims Edits	96,119	2.44	2.3	1
HCBS HelpDesk	1,580	Unknown	Unknown	0.5
Support Staff and Supervisor	N/A	Unknown	Unknown	3

During fiscal years 05-07, there has been a decrease in the number of claims edit for PA in the Kansas Medicaid fee for service programs as shown in Figure 1. In FY 08, the numbers of requests increased. The significant drop in the number of PA requests after FY 05 is, in part, the result of the implementation of the Medicare Part D program that began January 1, 2006. The Managed care expansion in FY 07 had a significant impact on the number of PA requests received as well. The past three years have shown a rise in the numbers of PA edits submitted.

Figure 1- Volume of PA Edits by Fiscal Year



	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Requested	104,938	88,302	82,267	91,326	96,119
Denied	56,345	47,268	40,799	42,758	47,295

Reductions in the volume of Medicaid PA requests due to the new Medicare Part D prescription drug program and the transfer of PA responsibilities for thousands of Medicaid recipients to an expanded HealthWave managed care program have enabled a shift in PA responsibilities to enhance medical management in other service areas. Examples of the new duties for the PA unit include:

- Processing PAs for the Prescription Drug List (PDL) was added in FY 03. This increased the number of nurses by three. Through attrition, two of these positions have not been filled and the job duties being absorbed by other staff members. Statistics indicate that 6,224 PDL requests were received with an average of 10.31 minutes to process each of these PA requests in FY 09. An optimal time of 12.10 minutes to process these types of PA requests is noted by the fiscal agent. This calculates to approximately two thirds of one full time position on the actual time, or three fourths of one full time position at the optimal time. These calculations are based on a 32.5 hour work week.
- Responsibility for the HCBS helpdesk being returned to the PA Unit in FY 05. This includes monitoring HCBS plans of care and tracking those services. Over the past five years, the numbers of inquiries per year average 2,100, no time tracking is done on this function by the fiscal agent.
- The transfer of duties of two RNs from the Medical Policy staff to the PA Unit in FY 05 to complete medical necessity reviews increased the prepay claim review statistics by an average of 34,584 claim edits per year over the past five years. The average time to process a claims edit is 2.44 minutes.

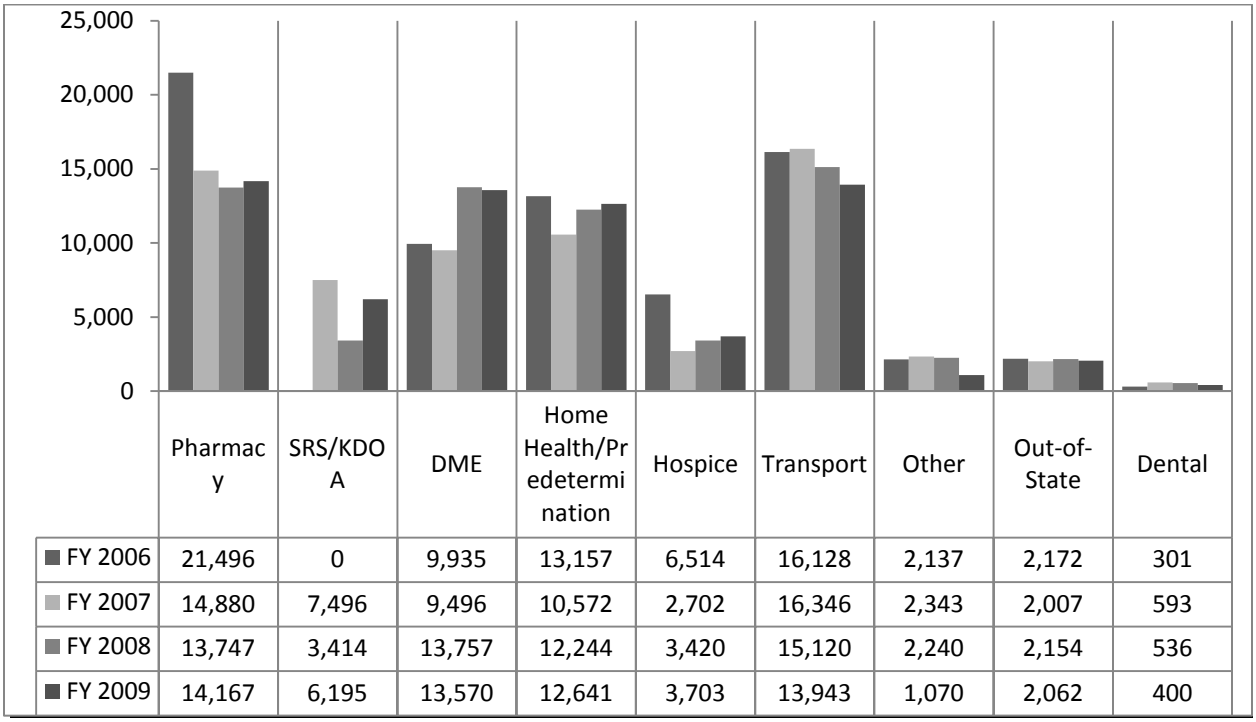
- Processing PAs for the Dental program was added in FY 06. Statistics indicate that over the past three fiscal years an average of 400 dental claim edits were processed with a reported average of 12.33 minutes to process these PA requests. An optimal time of 13.79 minutes to process these types of PA requests is noted by the fiscal agent for FYs 07 and 08. FY 09 indicates an optimal time of 19.3 minutes. In FY 09 data show an increase of more than 5 minutes per PA in the average time to process dental PAs. This was the result of an actual time study being completed by the fiscal agent.

Each Kansas Medicaid program operates according to a set of criteria that are based on program policy. KHPA sets the program limitations that are used to assess the PA requests received. Variances in the total numbers of requests often reflect policy changes, changes in federal mandates (i.e.; sterilization, prudent lay person, The Sixth Omnibus Budget Reconciliation Act, Outreach Program, Early Periodic Screening, Diagnosis, and Treatment Program, etc, and,) utilization of the services by beneficiaries. Examples of changes affecting the policies that have influenced the number of PA requests and their complexity are delineated below:

- An increase in number of Hospice receipts and time added to review Hospice Election Statement began in November 2007 and the average time to complete this new duty is reported to be an additional 3.25 minutes. As can be seen on Figure 4, an increase in the total number of Hospice receipts is reported in FY 06. This is the result of the Medicare Part D changes that were being implemented at that time.
- The Managed Care expansion dropped the total numbers of enrolled FFS beneficiaries in FY 07. This decreased the total numbers of beneficiaries served; this decrease is reflected in Figure 3.
- There were changes in drug coverage, DME, Home Health and other program criteria as they apply to services. Specific changes and reasons for those changes are included in the program reviews for each area. Examples include changes or inclusions of new services such as baclofen pumps, diabetic supplies, wheelchairs, Hyperbaric Oxygen Therapy, various drugs, etc.
- Some policy changes in the waivers administered by SRS and KDOA in late 2007 created a situation where targeted case management claims had to regularly receive PA when the plan of care limits were exceeded. Previously, this service did not typically require a PA to allow payment. These figures are encompassed within the Home Health/Predetermination category.

Figure 2 shows a breakdown of the program types along with the number of PA requests processed over the past five fiscal years. Please note that the figures in FY 06 and 07 for the Home Health/Predetermination category were included in the SRS/KDOA category.

Figure 2 – PA Requests by Program



	Pharmacy	SRS/KDOA	DME	Home Health/Predetermination	Hospice	Transport	Other	Out-of-State	Dental
FY 2006	21,496	0	9,935	13,157	6,514	16,128	2,137	2,172	301
FY 2007	14,880	7,496	9,496	10,572	2,702	16,346	2,343	2,007	593
FY 2008	13,747	3,414	13,757	12,244	3,420	15,120	2,240	2,154	536
FY 2009	14,167	6,195	13,570	12,641	3,703	13,943	1,070	2,062	400

The complexity of the criteria used to process the request for PA controls the processing time (see Figure 3a). Despite the fact that the number of PAs processed has shown a downward trend(see Figure 3b); staff requirements have remained constant according to the data provided by the fiscal agent as was reported in the Total Expenditures section.

Figure 3a – Average Minutes to Process

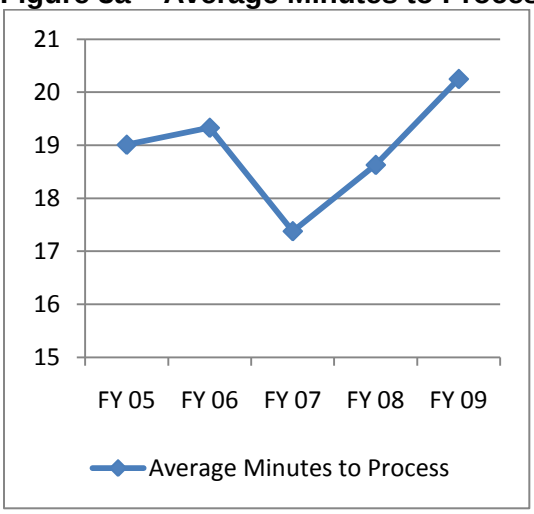
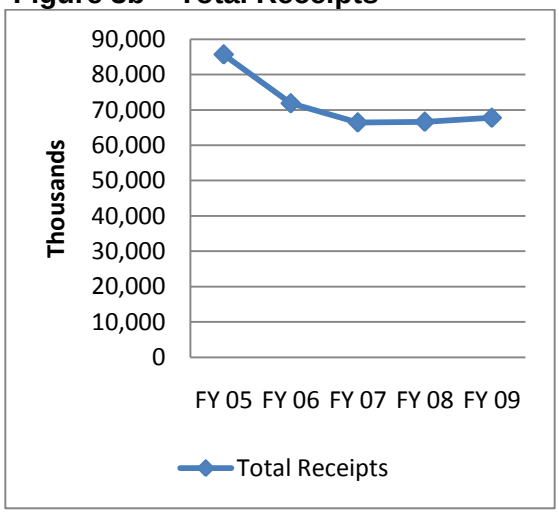


Figure 3b – Total Receipts



The automated PA system which was implemented in March 2009 for some pharmacy claims involves a process that is integrated within the MMIS. It uses preset criteria and claims data to automatically determine PA. If the PA criteria are met, a system-generated AutoPA is created and the claim is paid. The automated process allows providers and the fiscal agent to spend

less time completing the PA process. KHPA is currently evaluating the impact of the automated PA process.

As shown in Table 3 there was a decrease in the total number of claims edits processed by the PA Unit from fiscal year 05 to 06. The time it takes to process the claims edits has remained constant. In FY 05, the number of claims edits reflects that the MMIS at that time was still impacted by the recent implementation of a new MMIS system at the end of 2003 and dealing with a number of instances where claims needed to be reprocessed to be corrected, which resulted in inflated numbers being reported that we cannot adjust.

Table 3 – Claims Edits Processed by PA Unit

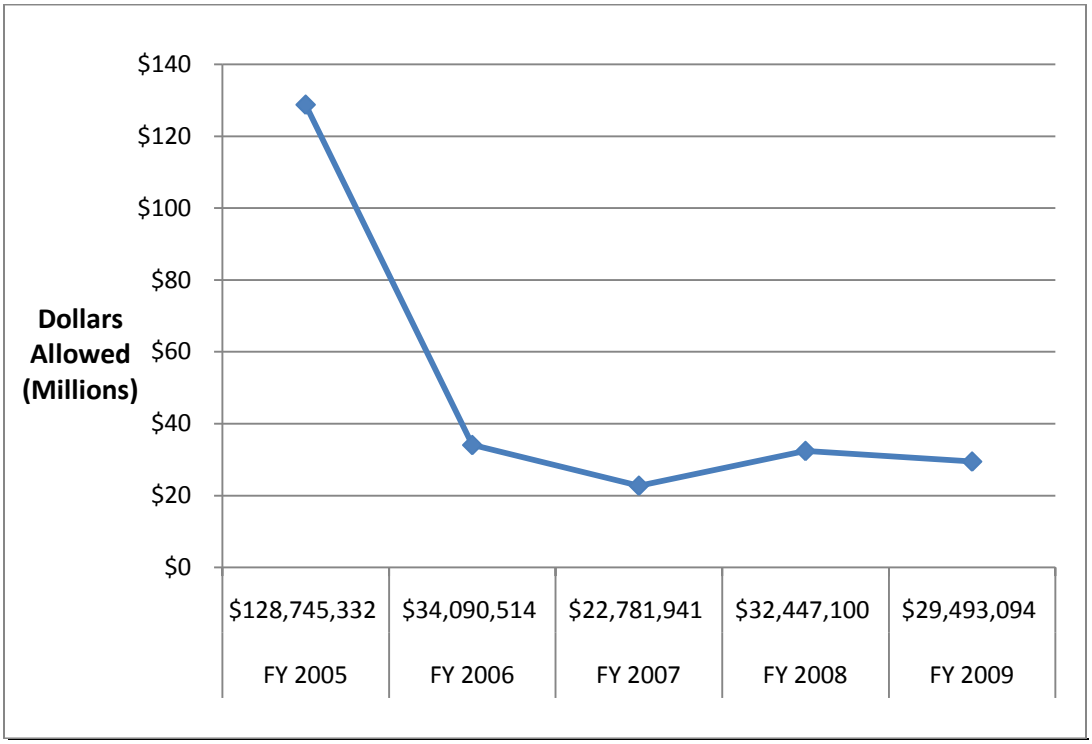
	FY 05	FY 06	FY 07	FY 08	FY 09
PA and Med Nec Edits	80,494	70,391	64,878	68,678	77,770
SOBRA Edits	24,444	17,911	17,389	22,648	18,349
Total Edits	104,938	88,302	82,267	91,326	96,119
Average Edit Process Time (Minutes)					2.44
# Persons to Process these claim edits/year	2.74	2.30	2.14	2.38	2.51

Formula used to calculate total time. (32.5 hr/wk x 4 wks x 12 months x 60 minutes = 93600 minutes/yr x 2.44 minutes = 228,384 minutes/yr divided by number of edits/yr.) {The 32.5 hr/wk is based on average working time for an individual due to time away for lunches, breaks, meetings, vacations, holidays, and possible illness.}

NOTE: Each claim may include numerous edits.

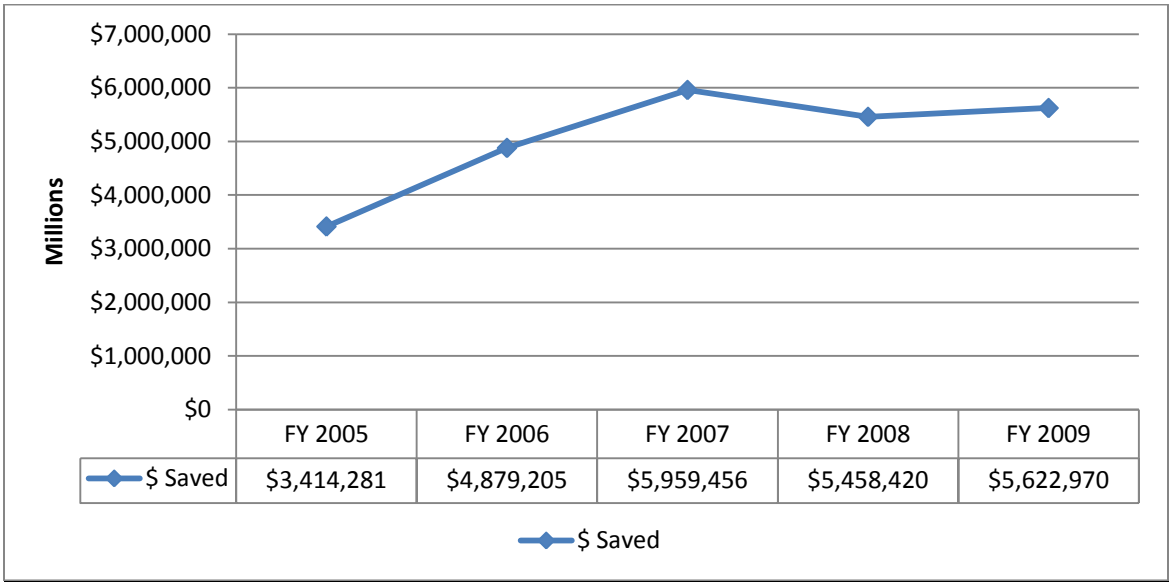
Figure 4 depicts that the dollar amount of claims denied through the PA unit compared to the allowed dollars. The last four years have shown that approximately $30 million in claims has been denied through the PA department annually. FY 05 numbers are inflated due to the MMIS system issues previously discussed.

Figure 4 – Allowed Dollars Denied by PA Unit



Cost avoidance is calculated as being the number of dollars that were denied from the actual PA requests submitted (see Figure 5). Cost avoidance is based only on the PA requests that are not related to pharmacy (or use a National Drug Code number). PAs that are entered for pharmacy do not have dollar amounts associated with them due to the point of sale process, and they do not have cost saving dollars reported. (The point of sale process is a system where the pharmacies are allowed to enter the claims data into a computer and receive an approval or denial at the time of the sale.) The pharmacy cost saving dollars is not calculated into the PA cost avoidance figures within the current system used by the fiscal agent. The last five years have shown an average annual cost avoidance of over 5 million dollars per year. During FY 09 a number of DME items were removed from the prior authorization requirement, which resulted in a decrease in the PA cost avoidance figure. The cost avoidance for the DME items that were removed from the PA requirement is now captured in the claims area.

Figure 5 – Cost Avoidance by FY



Program Evaluation

PA data demonstrates an overall decrease in the number of PAs over the past four years. A cost avoidance analysis indicates that Kansas Medicaid/Healthwave has avoided over 5 million dollars per year (not including pharmacy claims). It is noted that after allowing for the decrease in PA requests as a result of the Medicare Part D program, the PA numbers have remained fairly consistent. Factors that affect these numbers include program changes in the PA requirements. One such change involved the Home Health program's comprehensive review of its PA requests. Another example is the addition of the dental PA services with the transfer of the dental program from Doral to the fee for service program in July 1, 2006. Other factors include fluctuation in the numbers of beneficiaries served and how many are served through Managed Care Organizations (the PA process would not be included in this report for those individuals).

Federal and legislative mandates may periodically affect the total number of PA requests. Examples may include:

- The introduction of covering or not covering certain services for specific populations such as SOBRA.
- Federal legislation dictating coverage under the Prudent Lay Person Act.
- Federal legislation defining requirements for certain services such as the requirements that must be met prior to sterilization procedures.

Changes in the distributions of the beneficiaries among the various programs affect the number of PA requests. Factors that affect the numbers of PA requests include:

- The number of beneficiaries enrolled in MCOs.
- The addition and deletion of Medicaid/Healthwave programs served by the fiscal agent such as the introduction of processing the dental claims in July of 2006.

- General enrollment data which may indicate increases or decreases in the number of Medicaid/Healthwave beneficiaries at any given time.

The PA process clearly shows an overall cost savings to the program. PA also acts as a safeguard to assure that services are medically necessary and cost efficient. Prior authorization of services is an effective tool to monitor programs and prevent over-utilization of expensive services.

Recommendations

1. Continue the timely and accurate processing of PA requests (the goal is within 24 hours of receipt).
2. Continue monthly reporting as designed at the current time, with allowances made as situations arise.
3. Identify a way to capture the cost avoidance figures for pharmacy PA requests.
4. Look at ways to further automate the PA process. Explore the expansion of the automated PA process, which were implemented for some pharmacy products in March of 2009, to other areas.
5. Require justifications of individuals within the PA Unit by position with clear duties and time lines indicated by the fiscal agent.
6. Work toward the inclusion of call recordings in the future as a means of improving documentation.
7. Periodic review of current services on PA for evaluation of efficiency.